

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 331 Southway Drive, Southway, PLYMOUTH,  
Devon, PL6 6QR

**Pharmacy reference:** 1030870

**Type of pharmacy:** Community

**Date of inspection:** 01/12/2023

## Pharmacy context

The pharmacy is in a shopping precinct in Plymouth. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers a range of services including flu vaccinations, the NHS New Medicine Service (NMS) and the Community Pharmacy Consultation Service (CPCS). The pharmacy offers services to drug misusers. The pharmacy offers a delivery service.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy provides its services safely and effectively. It has suitable systems in place to identify and manage the risks associated with its services. Team members record any mistakes they make and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. And these procedures are reviewed and updated regularly. The pharmacy asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's private information safe. Pharmacy team members know how to protect the safety of vulnerable people.

### Inspector's evidence

The pharmacy had processes in place to identify, manage and reduce its risks. It had standard operating procedures (SOPs) which reflected the way the team worked. Each team member had an online learning account which held a record of the SOPs that had been read. The SOPs were reviewed regularly by both the superintendent pharmacist and the pharmacy team. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). Team members had clear lines of accountabilities and were clear on their job role. The pharmacy had risk assessments in place to cover its activities. And it had a written business continuity plan.

Pharmacy team members recorded any mistakes they made which were picked up during the final accuracy check, known as near misses, on a paper log. This was then transferred to an online reporting system at the end of the month. The trainee dispenser kept her own paper log of any errors they made and discussed this regularly with the responsible pharmacist (RP) and the manager to identify trends.

Dispensing errors that reached the patient were reported in a more detailed way using an online reporting tool. Team members considered why the mistake had happened and learned from their mistakes. The pharmacist and manager reviewed the errors regularly. When errors occurred, the pharmacy team discussed them and made changes to prevent them from happening again. The pharmacy team had recently reorganised and tidied the shelves of medicines to try and reduce the likelihood of errors. Medicines that looked or sounded alike were stored separately.

The pharmacy sent a large proportion of its prescriptions to be dispensed at a central hub. The hub used a robotic dispenser which meant that the error rate was very low. The manager could not recall receiving any prescriptions from the hub which had contained errors.

The pharmacy received regular training materials from the superintendent pharmacist's office which shared learning on incidents that had happened in other pharmacies. Members of the pharmacy team attended a regular conference calls and meetings with other nearby branches of the chain where they discussed incidents and learnings as a group.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. There was information for people displayed in the retail area about how to provide the pharmacy with feedback. Any complaints were passed straight to the pharmacist or the manager to deal with. The

manager made sure to pass any compliments received to the team. Public liability and professional indemnity insurances were in place.

The pharmacy kept a record of who had acted as the RP each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. Balance checks were completed regularly and any discrepancies were promptly rectified. A random balance check was accurate. Patient returned CDs were recorded in a separate register. The pharmacy maintained records of private prescriptions on a register on the patient medication record (PMR) system. The team said that the number of private prescriptions they dispensed was very low. The pharmacy kept appropriate records of any emergency supplies it made through the Community Pharmacy Consultation Service. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed.

All team members completed yearly training on information governance and general data protection regulations. Patient data and confidential waste were dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. A privacy policy and a fair data use statement were displayed in the retail area. Team members ensured that they used their own NHS smart cards. Verbal consent was obtained before summary care records were accessed and a record of access was made on the person's PMR.

All staff were trained to an appropriate level on safeguarding. The RP had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training. And all other members of the pharmacy team had completed appropriate training on safeguarding. Local contacts for the referral of concerns were available. Team members were aware of signs of concerns requiring escalation and knew what action to take. The RP had experience of escalating safeguarding concerns and described scenarios in which they had intervened in the past.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy employs a team of people who work effectively in their roles. Pharmacy team members complete regular learning to keep their knowledge and skills up to date. They work well together by engaging in regular conversations to identify how improvements can be made in the pharmacy. And they understand how to raise concerns at work.

### Inspector's evidence

On the day of the inspection, the RP was a long-term locum pharmacist. The manager was a dispenser and there was a trainee dispenser who was covering the medicines counter. A new dispenser was planned to start in the coming weeks, moving from a different branch.

The pharmacy team were coping with the workload well and dispensing was up to date. The pharmacy team felt very well supported by the manager and the area manager. It was clear that they worked well together and supported each other. They had regular 'huddles' to share information with each other. The team were encouraged to discuss concerns and give feedback to the manager, who they found to be receptive to ideas and suggestions. The team felt able to make suggestions for change to improve efficiency and safety. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

Team members were seen to give appropriate advice to people in the pharmacy. And they referred to the RP for further clarification when needed. The trainee dispenser knew what tasks could not be completed if the RP was not in the pharmacy.

Team members were given time during working hours to learn. They accessed learning on an e-learning platform. Recent learning had included reading new SOPs and learning about new products. They encouraged each other to learn and helped each other. Each team member had regular appraisals where they could discuss their progress. The company was supportive of development opportunities.

The manager felt that the targets set were manageable. And the pharmacists did not let targets affect their professional judgement. They ensured all services provided were appropriate for the person requesting them.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy has a soundproofed room where people can have private conversations with members of the pharmacy team. The pharmacy is adequately secured to prevent unauthorised access.

### Inspector's evidence

The pharmacy was located in a small row of shops in a residential area of Plymouth. There was a small, well-presented retail area which led to a healthcare counter and the dispensary. A barrier was installed to prevent unauthorised access to the dispensary. The dispensary was well organised but bench space was limited. Stock was stored neatly on shelves around the perimeter of the dispensary. The fixtures and fittings were well maintained. The pharmacy had a consultation room that was clearly advertised. It was of an adequate size and was soundproofed to allow conversations to take place in private. It was unlocked during the inspection and the manager said that the team were unsure where the keys were. But they resolved to find them. In the meantime, no medicines or personal information would be stored in the room. Prescriptions awaiting collection were stored using a retrieval system and confidential information was not visible to waiting customers. Lighting was appropriate and the temperature was satisfactory for the provision of healthcare and the storage of medicines.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy team make sure that people with different needs can access its various services. The pharmacy supplies medicines safely to people with appropriate advice to ensure they are used correctly. Team members take steps to identify people prescribed high-risk medicines to ensure that they are given additional information. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy accepts unwanted medicines and disposes of them appropriately.

### Inspector's evidence

The pharmacy had step-free access and was wheelchair accessible. It had an automatic door. Plentiful parking was available nearby. The pharmacy could provide additional support for people with disabilities, such as producing large print labels. A range of health-related posters and leaflets were displayed. Team members explained that if a person requested a service not offered by the pharmacy at the time, they referred them to other nearby pharmacies or providers, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear flow to ensure prescriptions were dispensed safely. Team members used baskets to store dispensed prescriptions and medicines to prevent transfer between patients as well as to organise the workload. There were designated areas to dispense and accuracy check prescriptions. Team members initialled the labels of medicines when they dispensed and checked them.

Coloured alert stickers were used to highlight prescriptions containing fridge items and CDs in schedules 2 and 3. The RP described that they checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. And they usually made records of this advice on the PMR.

The pharmacy offered a range of additional services including flu vaccinations. The signed patient group direction for the current flu vaccination service was available. The pharmacy supplied opioid replacement medicines to a small number of people, some of whom were supervised taking their medication. The RP liaised with the drug and alcohol team and the person's key worker in the event of any concerns or issues. The pharmacy offered the NHS New Medicines Service. The RP contacted people prescribed new medicines to check how they were getting on and to offer any advice needed.

The pharmacy had a health promotion zone and provided advice to people on living healthy lifestyles. The pharmacy was registered to receive referrals as part of the Community Pharmacy Consultation service (CPCS) and received regular referrals, from both NHS111 and GP practices.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate as part of the Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. They were aware of the new requirement to only dispense valproate in original packs to ensure people receiving it could see the warning about the risks of becoming pregnant whilst taking it. The RP had regular conversations with the people at risk who were prescribed valproate to ensure they were on

adequate contraception. And records were made on the PMR.

The dispensary stock was generally arranged alphabetically on shelves. It was well organised. Date checking was undertaken regularly and records were kept. Spot checks revealed no date-expired medicines or mixed batches. Prescriptions containing omissions were appropriately managed and the prescription was kept with the balance until it was collected. Stock was obtained from reputable sources. Records of recalls and alerts were actioned promptly. Relevant alerts were printed and stored with any quarantined stock.

CDs were stored in accordance with legal requirements in approved cabinets. A denaturing kit was available so that any CDs awaiting destruction could be processed. Expired CDs were clearly marked and segregated in the cabinet. Patient returned CDs were recorded in a register and destroyed in the presence of a witness. The dispensary fridge was clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services. It keeps these clean, tidy and well-maintained. The pharmacy uses its equipment in a way that protects people's confidential information.

### Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Team members had access to the internet to support them in obtaining current information. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view.

The pharmacy had clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines. This helped to reduce any risk of cross contamination. A range of consumables and equipment to support the services provided by the pharmacy was available within the consultation room. Electrical equipment was visibly free of wear and tear and in good working order. PAT testing stickers were present and in date. The sinks and fridges in the dispensary were clean and well-maintained.

### What do the summary findings for each principle mean?

Finding	Meaning
✓ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✓ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.